Unified Medical Command Update

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Joint Health Service Support

Interoperability & Interdependency

Improved Effectiveness & Efficiencies

Provide Peacetime Benefit

This Is Not a New Idea!

- NDAA FY 2000 tasked SECDEF to examine merits & feasibility of:
  - Joint Medical Command
  - Joint Training Curriculum
  - Unified chain of command and budgeting authority
- March 2001 RAND Study
  - Considered 5 alternative organizational structures
  - Conclusions:
    - MHS-unique dual missions of Readiness & Benefits both compliment and compete w/each other.
    - Critical need for reorganization of TRICARE management
    - The “additional benefits of a joint command are more difficult to assess”.
- 10 Aug 2001 CJCS memo to SECDEF recommended:

“organization changes to clarify responsibility and accountability” within Military Health System

PBD 753 Language

Direct the Under Secretary of Defense (P&R) to work with the Chairman of the Joint Chiefs of Staff to develop an implementation plan for a Joint Medical Command by the FY 2008 – FY 2013 Program/Budget Review.

PBD 753 calls for the development of an *implementation plan* for a joint medical command, rather than a feasibility study for a joint medical command or an assessment of the current MHS construct

Working Group Membership

Co-Leads

Joint Staff- Maj Gen Joseph Kelley, USAF

USD(P&R)- Dr. David Tornberg, Acting Director, TMA

Members

Joint Staff- COL Jay Harmon

USD(C)- Ms. Nancy Jeanne Rosenberg

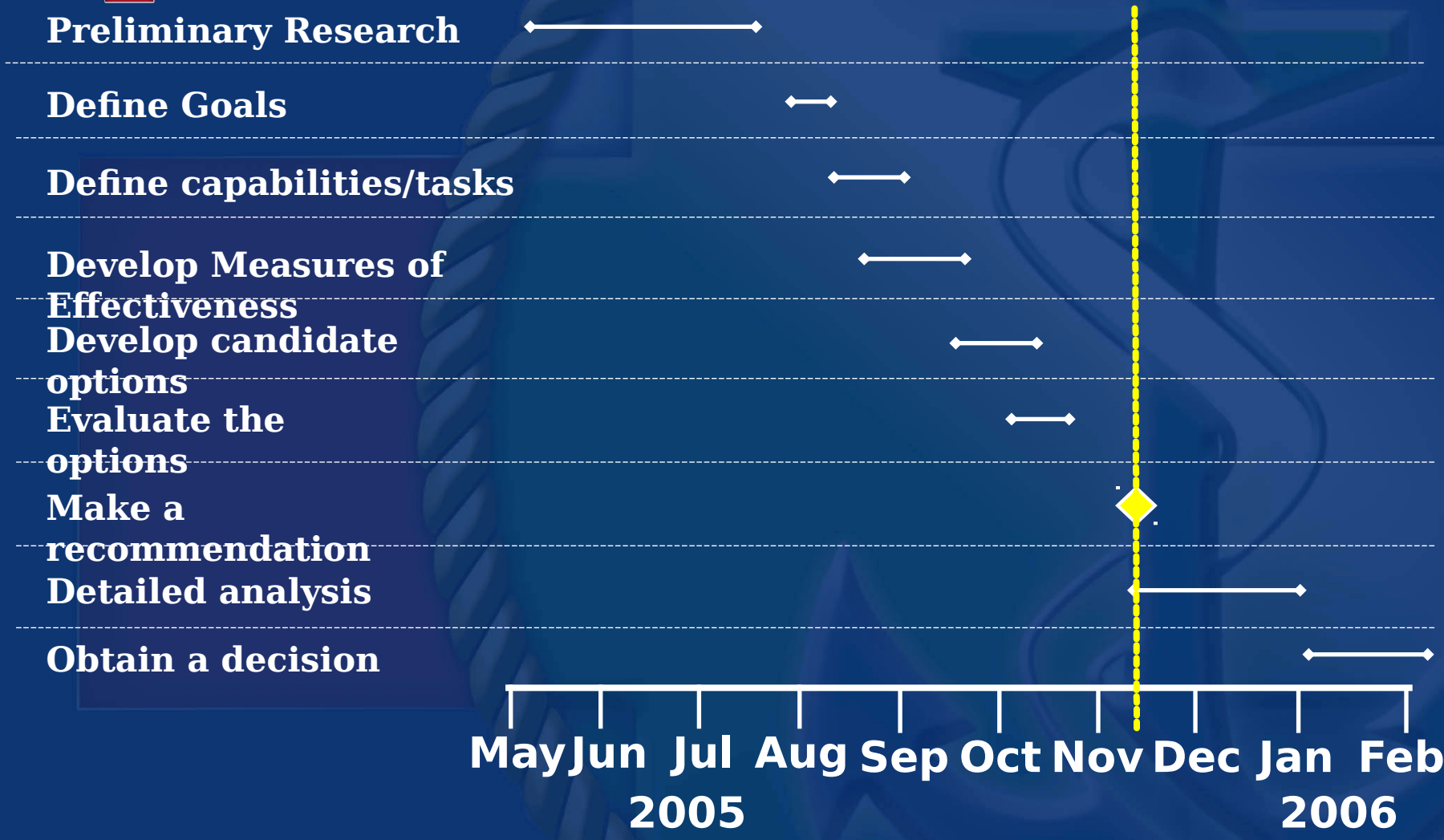
ASD(HA)- COL Thom Kurmel, COL Ray Cunningham

Army- COL Ben DeKoning, Mr. Richard Beauchemin

Navy- RDML Dave Smith, CAPT Toni Whitmeyer

Air Force- Col Mark Hamilton, Col Ken Knight

Working Group Method and Timelines



Process mirrors the Joint Capabilities Integration and Development System (J

What problem(s) are we trying to solve?

- Current MHS governance is fragmented among several paths; no single overarching structure
- Achieving unity of effort by maximizing the use of available resources & prioritizing mission requirements is challenging
- No single point of accountability
- Includes many redundancies; multiple headquarters, infrastructure
- Balancing between readiness and benefit missions difficult
- The Services do not have uniform readiness standards
- Interoperability of people & equipment in theater is challenging

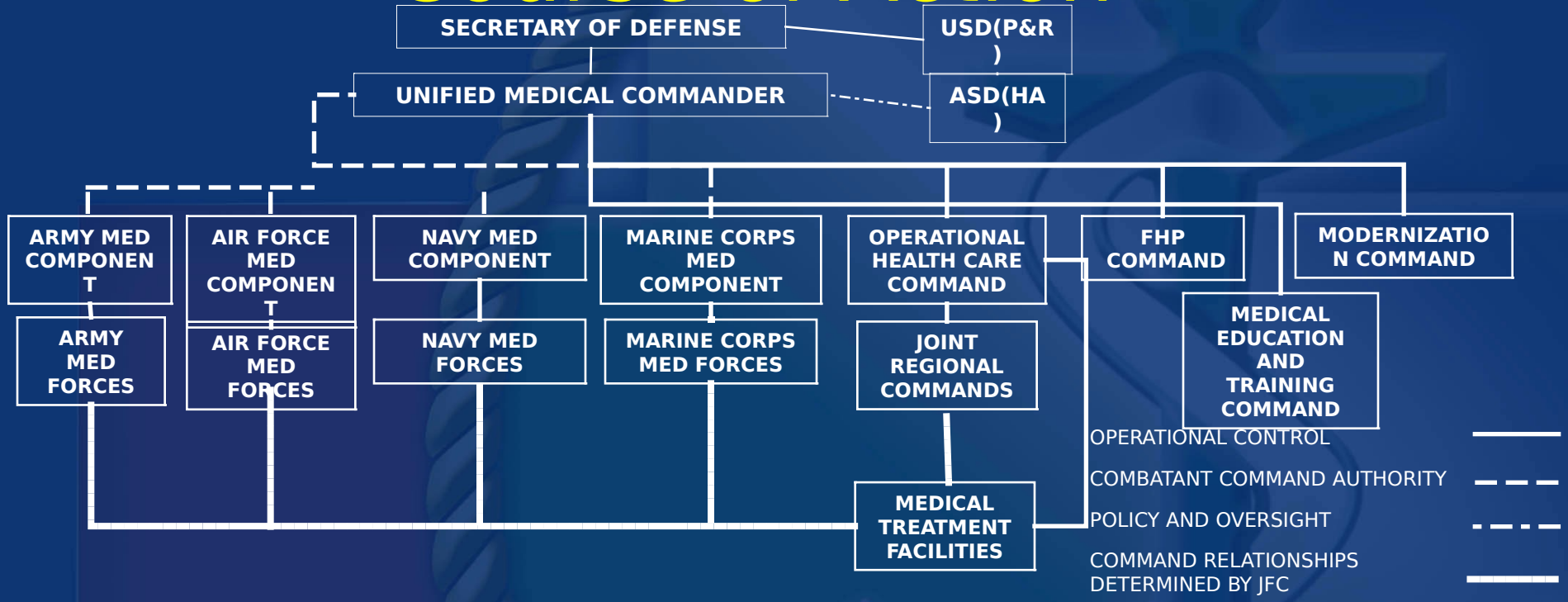
How does establishment of a J/UMC address these issues?

- Unifies command under one authority
- Provides single point of accountability
- Establishes single accounting system
  - One metrics system to measure performance/costs
- Facilitates jointly staffed facilities
- Consolidates/optimizes like services
  - IM/IT
  - Training
  - Facilities
  - Headquarters functions
  - Logistics/Acquisition
  - R & D
  - Resources
  - Preventive Medicine, etc.

COCOM perspective – potential of a Joint/Unified Medical Command

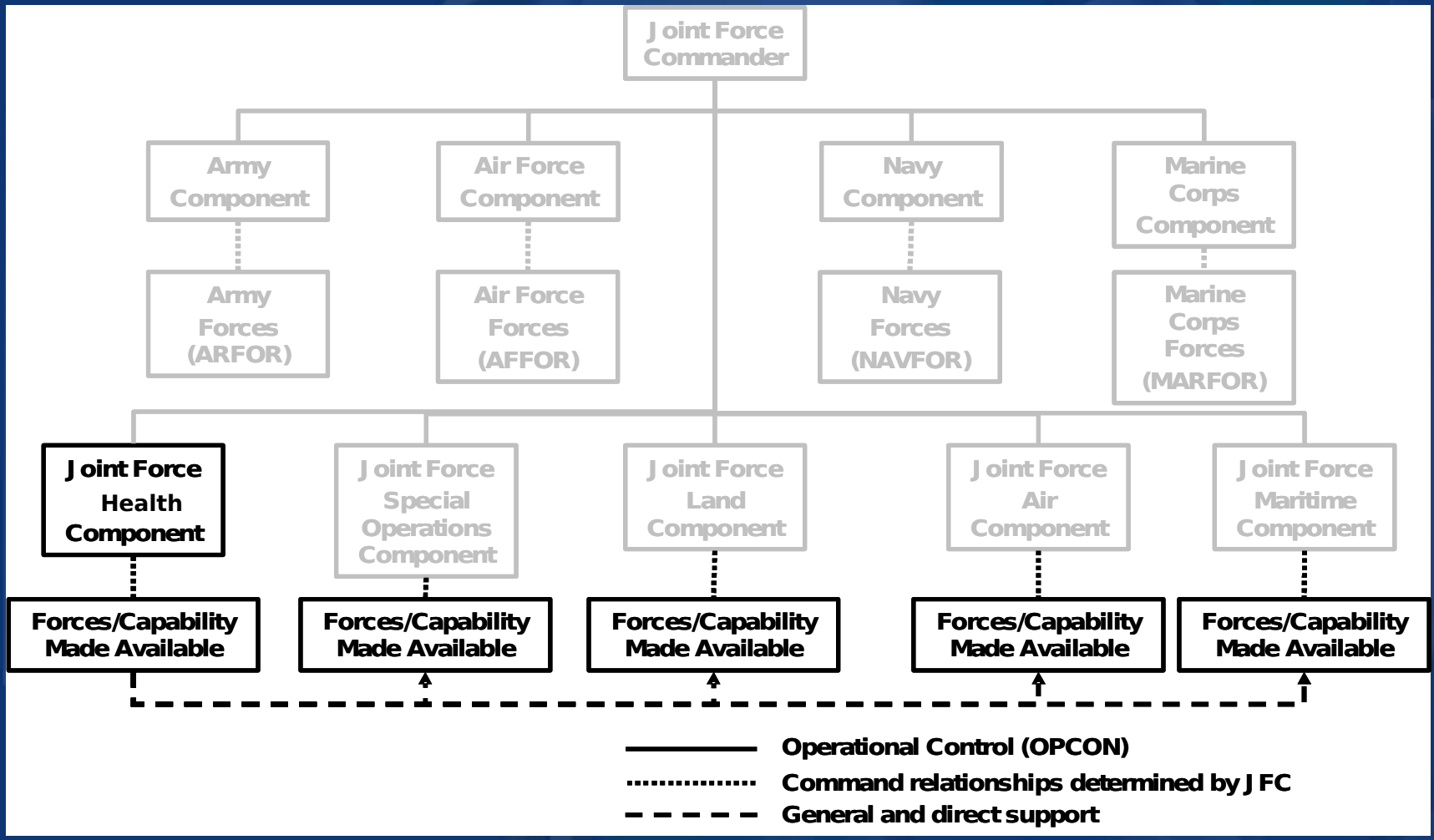
- A Global Medical Force Provider
  - Increased integration for all elements of medical command and control
  - Increased peacetime effectiveness and ability to quickly transition to war
  - Rapidly deployable and flexible medical capability
  - Close the gap on medical situational awareness/common operating picture & information sharing

J/UMCWG Recommended Course of Action



Capability	Services	UMC	Health Affairs
Recruiting, initial entry training, promotion, professional development	●		
Medical Training		●	
Operational control of Level 1 and 2 medical personnel and organizations	●		
Operational control of Level 3 medical organizations		●	
Operational control of MTFs and clinics		●	
Combatant Command authority over Component medical organizations		●	
Management of purchased care		●	
Management of MTF infrastructure		●	
Policy and oversight			●

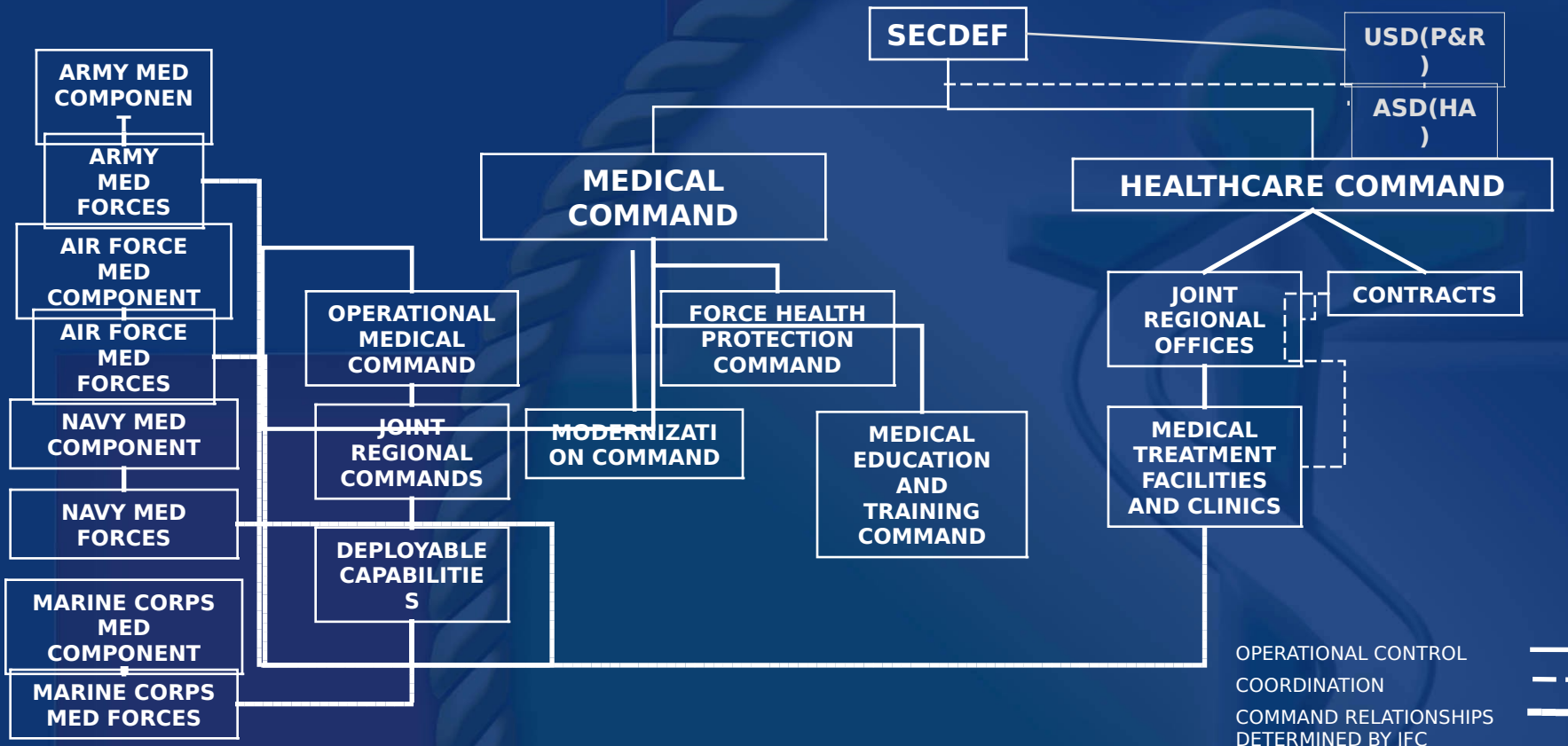
CONOPS Deployment Mode



USD (P&R) Direction 23 Nov 2005

Develop recommendations for two specific commands:

- A single joint/unified medical command responsible for all market areas
- A joint/unified medical command responsible for Operational/Deployed medicine



Capability	Services	MED CMD	HC CMD	Health Affairs
Policy and oversight				●
Recruiting, initial entry training, promotion, professional development	●			
Medical Training		●		
Operational control of embedded/organic medical personnel and organizations	●	●		
Operational control of Theater-level medical organizations		●		
Operational control of MTFs and clinics			●	
Combatant Command authority over Component medical organizations				
Management of purchased care contracts			●	
Management of MTF infrastructure			●	

What's Next?

- Draft CONOPS and overarching frameworks sent out in Joint Staff tasker to COCOMs and Services
  - Majority of COCOMs and Services support single command option
  - Specifics reconciled and CONOPS updated
- Awaiting completion of CNA manpower and cost analysis
- Tank Brief TBD
- MHSER Brief TBD
- Create top-level implementation plan IAW PBD 753